King County Request to Opt Back in Medical Coverage

Office Use Only	Date Received	Processed By	Effective Date

- Submit this form to opt yourself or family members back in medical coverage within 60 days of losing your other medical coverage
- List family members opting back in with you on an Add Family Members for Benefit Coverage Form
- Return all forms to Benefits & Well-Being, Yesler Building YES-HR-0500, 400 Yesler Way, Seattle WA 98104-2683 (phone 206.684.1556/fax 206.684.1925)

■ **I/we (family members listed on separate add/delete family members form) are opting back in medical coverage because I/we:**

☐ Lost coverage due to a change in employment (mine or my spouse/domestic partner's)

Other Employer Name _____

Other Medical Plan Name _____

Name of Primary Covered Person _____

Person's Soc Sec No _____ Relationship to Employee _____

Coverage End Date _____

☐ Lost coverage due to divorce/dissolution of domestic partnership -- must attach termination of marriage/domestic partnership statement.

☐ Lost coverage due to death of spouse/domestic partner on (date) _____

☐ Lost coverage due to these circumstances (explain) _____

_____

_____

_____

■ **Opt me/us back in:**

☐ KingCare (Ethix/Aetna) Basic
☐ KingCare (Ethix/Aetna) Preferred
☐ PacifiCare Choice
☐ PacifiCare HMO
☐ VM/GH Alliant

■ **Authorization**

I (the employee named below) and/or the family members I've listed on the separate add/delete family members form have lost coverage and want to enroll in King County's medical coverage outside of regular open enrollment. I understand my request must be submitted within 60 days of loss in coverage and King County coverage will begin on the first of the month following the month coverage is lost. If the conditions of my employment require me to pay monthly premiums, I understand I must pay premiums retroactive to the date my King County coverage begins. If I cover a domestic partner and/or domestic partner's child(ren), I understand deductions based on the taxable value of their benefits will be deducted from my paycheck retroactive to the date the coverage begins.

Employee Signature _____ **Date Signed** _____

Printed Name _____ Contact Phone (_____)_____

Paid ☐ 5th & 20th each month Pay ID No_____ Soc Sec No _____
☐ Every other Thursday